VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 30, 2013

Mr. Thomas Dee, Administrator
Southwestern Vermont Medical Center
100 Hospital Drive
Bennington, VT 05201

Provider ID #: 470012

Dear Mr. Dee:

The Division of Licensing and Protection completed a survey at your facility on October 8, 2013. The purpose of the survey was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on October 28, 2013. On October 28, 2013 you submitted amendments and those were accepted on October 30, 2013.

Sincerely,

Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
State Survey Agency Director

FK:jl

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470012	A. BUILDING _____ B. WING _____	C 10/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VERMONT MEDICAL CENTER	100 HOSPITAL DRIVE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, interview and record reviews conducted on days of survey, the Condition of Participation: Patient Rights was not met as evidenced by the hospital's failure to protect and promote the rights of each patient to assure that safe care was provided. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. Refer to tags: A-0131, 0144, 0145, 0147	A 115	10/28/13 The remaining two staff members are on medical leave and will not be permitted to return to duty until the competency has been completed. The understanding and competency of this education will be assessed by obtaining a passing score on a written or online test. All new staff will be provided the same material as a component of their orientation program. b. Emergency Department and Access Services department leadership will conduct regular, one-on-one meetings ("rounding on staff") with all employees to assess their competency with patient rights and the culture of safety. Any lack of understanding or noncompliance identified in these meetings will be immediately and directly addressed with the staff member through the Hospital's Corrective Action policy.	10/29/13 Ongoing Ongoing
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED	A 131	POC accepted FKelly RN MSN 10/30/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, interview and record reviews conducted on days of survey, the Condition of Participation: Patient Rights was not met as evidenced by the hospital's failure to protect and promote the rights of each patient to assure that safe care was provided. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. Refer to tags: A-0131, 0144, 0145, 0147	A 115	Correction Action Planning Process: To formally manage improvement opportunities identified from the Division of Licensing and Protection survey, the Hospital immediately launched a comprehensive response, including the following: • An executive team was formed to oversee the response to the items identified at the Exit Conference. This team includes members of Executive Management, Administrative Directors, Directors, Physician leaders and subject matter experts.	10/11/13
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED	A 131	• A champion was identified for each of the Conditions of Participation and Standards identified at the Exit Conference, and subsequently modified upon receipt of the Statement of Deficiencies. These champions and their underlying team members have high level of physician,	10/11/13

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President & CEO 10/25/13

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POC accepted F. McIntosh / FKellerman 10/28/13

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A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED	A 131		

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A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED	A 131	A communication and education plan utilizing this model has been implemented to address all subject matters identified in	Ongoing

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A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED	A 131		

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A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED	A 131		

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A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED	A 131		

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PRINTED: 10/15/2013
FORM APPROVED
OMB NO. 0938-0391

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A 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted on 10/7/13 - 10/8/13 by the Division of Licensing and Protection .The following regulatory violations were identified: Based on information obtained through staff interviews and record reviews, an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. In addition, the hospital was determined not to be in compliance with Conditions of Participation for: Patient Rights, Quality Assurance/Performance Improvement, Nursing Services and Emergency Services.	A 000	Tag A131 (cont'd) highlighted both with shading and a black box to clearly identify it. Implementation: The ED Clinical Nurse Specialist (or other designated RN) and Access Services supervisor have provided direct, one-on-one education with staff on the changes to the policy and the Consent form which has been documented and tracked via a sign-off sheet. 100% of ED and Access Services (90%) staff have completed the training except for one RN on medical leave who will not be permitted to return to duty until the training has been completed. 10/28/13 1 access on bereavement lv, and 1 out of care The understanding of this education will be assessed by obtaining a passing score on a written or online test.	10/24/13 10/29/13
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, interview and record reviews conducted on days of survey, the Condition of Participation: Patient Rights was not met as evidenced by the hospital's failure to protect and promote the rights of each patient to assure that safe care was provided. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. Refer to tags: A-0131, 0144, 0145, 0147	A 115	Monitoring: Beginning on October 16, 2013, each business day, the Health Information Services department will monitor 100% of consent forms for patient encounters in the Emergency Department to ensure compliance and will notify the department manager of any deviations identified for immediate follow up; weekend encounters shall be reviewed on the following Monday. Upon 100% compliance for a period of one month, the Health Information Services department will monitor a sample of consents as part of the Health Information Services Record Review plan. The results of this monitoring will be reported to the Executive Compliance Committee monthly until 100% compliance is achieved and quarterly thereafter and in the Privacy Officer's annual report to the same committee.	Ongoing Ongoing
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED	A 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	470012	A. BUILDING _____ B. WING _____	C 10/08/2013

NAME OF PRDVIDER DR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 131	Continued From page 1 CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on interview and record review, the nursing staff in the Emergency Department failed to follow hospital policy during the process of obtaining consent for treatment for one applicable patient. (Patient #1) Findings include: On 9/24/13 Patient #1 was transported to the ED via ambulance with complaints of pain and other symptoms. Once in the ED it is responsibility of staff to obtain consent for treatment. Per hospital policy Informed Consent last revised 6/18/13 states " Valid informed consent must be obtained from each patient prior to any medical procedure or treatment .....". For the Emergency Department the policy titled Consent, last revised 8/27/13 states regarding the purpose for consent " To obtain written permission on all Emergency Department patients unless unable to sign due to unconscious state or life threatening emergency when not accompanied by a party responsible for signing permission" . After Patient #1 was placed in bay #11 on 9/24/13 and the Triage process was completed, Registrar	A 131	**Tag A131 (cont'd)** Executive Responsible: Chief Information Officer.	

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A 131	Continued From page 2 #1 from Access Services approached the patient to obtain his/her signature for treatment and to review insurance information and demographics. When Patient #1 was not responding to Registrar #1, the Registrar spoke to Nurse #1 informing her that s/he thought Patient #1 was dead and no signature for treatment was obtained. Nurse #1 took the consent form and signed for treatment. Per interview on 10/8/13 at 1:58 PM, Nurse #1 confirmed s/he had signed the consent form for Patient #1 to receive treatment in the ED, informing the Registrar Patient #1 was not answering any questions. However, per interview on 10/8/13 at 9:08 AM the Clinical Nurse Specialist for the ED stated "We sign that the patient is unable to sign and the reason why they can't sign". Per review of Patient #1's "Uniform Consent and Authorization to Release Information" form noted the signature of Nurse #1 is noted and dated on the designated line which read: " If Person Representative, describe relationship".	A 131		
A144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the hospital failed to assure immediate interventions were implemented for a patient who demonstrated a reported change in condition shortly after arrival to the Emergency Department and nursing staff failed to follow hospital policy and standards of practice to assure care and services were delivered in a safe setting for 1 applicable patient. (Patient #1) Findings include:	A 144	**Tag A 144** Plan for Correction: The Chest Pain protocol was reviewed, found to be sufficient, and it was determined that it did not apply to this patient as this patient's complaints included back pain and stomach (abdominal) pain. The implementation of the Chest Pain protocol, which includes administration of aspirin, would not have been appropriate until an acute abdominal process (*e.g.*, perforated gastric ulcer, dissecting abdominal aortic aneurysm) was ruled out. However, oxygen and cardiac monitoring should have been continued upon arrival to the Emergency Department. Therefore, the Triage Nursing Roles and Responsibilities policy has been revised.	10/23/2013 10/20/13

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A 144	Continued From page 3 Per record review, Patient #1 arrived via ambulance to the Emergency Department (ED) on 9/24/13 at 23:07. Patient #1's medical history contained multiple co-morbidities to include: Type 2 Diabetes mellitus; Epilepsy with severe seizure disorder; End Stage Renal Disease (ESRD) requiring dialysis treatments 3 x per wk; sleep apnea; asthma, obesity, hypothyroidism and Bipolar disorder. Per Emergency Medical Services (EMS)/Rescue Squad "Prehospital Care Report" for 9/24/13 at 22:30, Patient #1 was complaining of severe back pain, relating it to a fall which occurred on 9/14/13 and a recent cortisone injection. The report also noted Patient #1 was observed to have "...dry heaves...complained of stomach pain....s/he is short of breath...starting to breath rapidly...Also having some chest pain...Pt put on 3 lit (liters) of 02 (oxygen) nasal canula pt noting that O2 did help with breathing". Per interview on 10/8/13 at 11:40 AM, a Advanced EMT #1 (Emergency Medical Technician) who was part of Patient #1's transport team to the ED on 9/24/13 confirmed the patient was anxious. EMT #1 stated because of Patient #1's presenting symptoms to include continuous low blood pressure readings (85/60, 84/54. & 76/56) and the inability to establish an IV, the Paramedic was requested to arrive at the scene for assistance. EMT #1 also stated Patient #1 was placed on a 4 lead cardiac monitor but frequent artifact was noted due to the patient's restless movement, discomfort and anxiety. Upon arrival EMS staff were directed to place Patient #1 in bay #11, a large 2 bed area often used for trauma cases. Nurse #1, assigned to Triage, began the initial Triage process by entering demographic information into the	A 144	**Tag A144 (cont'd)** The Hospital policy entitled Triage Nurse Roles and Responsibilities was revised to require that patients arriving on oxygen and/or cardiac monitoring have these continued until the physician evaluation has been completed. The Hospital has modified its electronic medical record to provide a new standardized template for taking and documenting handoffs ("handovers") from Emergency Medical Services (EMS) members to the triage nurse in the Emergency Department. This new template ensures that all essential elements of an EMS-to-triage nurse transfer of care will be obtained and addressed as well as documented. Completion of this template is required for 100% of patients who arrive by EMS. The Hospital policies entitled Delivery of Care and Nursing Responsibilities were revised to include a new provision requiring that patients be reassessed by the nurse for any reported change in condition. Implementation: The ED Clinical Nurse Specialist (or other designated RN) has provided direct, one-on-one education with ED nursing staff on the changes to the following policies: Triage Nurse Roles and Responsibilities, Delivery of Care and Nursing Responsibilities, as well as the EMS handoff ("handover") documentation requirement. This education has been documented and tracked via a sign-off sheet. 97% of ED nursing staff has completed the training except for one RN on medical leave who will not be permitted to return to duty until the training has been completed. The understanding of this education will be assessed by obtaining a passing score on a written or online test.	10/20/13 10/23/13 10/20/13 10/24/13 10/29/13

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A 144	Continued From page 4 Electronic Medical Record (EMR) but had not assisted with the patient's transfer. Report was provided by EMS staff to Nurse #1 and with the assistance of an ED Technician, Patient #1 was transferred to the ED stretcher by EMS staff. Per EMT #1 , Patient #1 was removed from the Rescue Squad Cardiac monitor and oxygen and assistance was provided to the ED Technician to obtain a blood pressure, which process was difficult due to patient's restlessness and EMT #1 stated s/he provided Patient #1 reassurance due to the patient's continued anxiety. Per interview on 10/7/13 at 1:58 PM, Nurse #1 confirmed she had obtained a report from EMS regarding Patient #1 to include back pain, shortness of breath and stomach pain. "S/he was yelling...appeared to be in quite a bit of pain". Nurse #1 further stated s/he had cared for Patient #1 in the past during previous ED visits. Nurse #1 rated the patient's pain to be a "10" (on a 1-10 pain scale/10 being the worse level of pain) but noted Patient #1 did not answer Nurse #1's questions during the Triage process stating the patient was yelling in pain. At the completion of the Triage process that was conducted on the opposite side of the large trauma bay, Nurse #1 left the area. No direction was provided by Nurse #1 to other ED staff to place Patient #1 on a cardiac monitor or apply oxygen. The only vital signs recorded, taken by the ED technician, included: B/P 130/96, pulse 88 and oxygen level via pulse ox meter was reported at 96 on room air. Nurse #2, who was assigned to Patient #1, sat at the nurses station located opposite the trauma bay #11 and observed Patient #1's arrival by EMS. Per interview on 10/7/13 at 12:01 PM,	A 144	**Tag A144 (cont'd)** Monitoring: The ED nursing leadership (or other designated RN) will conduct chart audits of 100% of Emergency Department patient encounters to validate compliance with the Triage Nurse Roles and Responsibilities, Delivery of Care and Nursing Responsibilities policies, specifically regarding the nurse's response to any reported change in patient condition. This audit will also review the completion of the EMS handoff ("handover") protocol, which includes continuation of cardiac monitoring and oxygen, on patient arrivals by Emergency Medical Services squads. This monitoring will occur each business day (with weekend encounters reviewed on the following Monday) for a period of at least ninety days, the results of which will be assessed as part of the Hospital's QA/PI program. The reviewer will notify the department manager of any deviations identified for immediate follow up. The results of this monitoring will be reported to the Administrative Safety Quality Committee monthly, which minutes are reported to and reviewed by the Board Safety Quality Committee. Executive Responsible: Chief Nursing Officer.	10/28/13 Ongoing Ongoing

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A 144	Continued From page 5 Nurse #2 stated s/he was on the computer and did not get up to assist staff and EMS with the patient's transfer or assess the patient's physical status once the ED technician had completed vital signs. Nurse #2 stated " ...the patient was crying out in pain...I continued my charting". Nurse #1 stated staff had dimmed the lights in bay #11 to "...make the patient more comfortable...I would glance over to see her/him move their arm or leg". Per ED Triage Protocol: Chest Pain, last reviewed 02/13 states "Triage protocols are an effective way to provide timely diagnostics and gain efficiencies for provision of services to select patients based on presenting signs and symptoms. The use of standardized approach to triage to facilitate medical decision making by the provider." Nursing orders for ED Triage for chest pain includes : "Vital signs; 02 per titration guidelines; saline well (IV) and cardiac monitor". Neither Triage Nurse #1 or Nurse #2 made any effort to follow hospital protocol. At approximately 10 minutes after admission to the ED between 2220-2224 on 9/24/13 Access Services Registrar #1 entered bay #11 to complete the registration process, verify information and obtain a signature for treatment from Patient #1. Per telephone interview on 10/7/13 at 4:00 PM. Registrar #1 stated "I spoke to her/him a couple of times (Patient #1)...her/his head was to the side and her/his mouth was open. There was no response from her/his eyes. I was quite close to her/him. I was up by her/his head. I looked at her/his chest area to see if there was any movement." Registrar #1 reported s/he quickly went to the end of the trauma bay area and "I said to the nurses who were nearby. I said	A 144		

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A 144	Continued From page 6 s/he (Patient #1) is dead. One of the nurses said 'oh s/he's playing possum'.....'I'll sign your papers for her/him'....She signed my paper and at that point I left the emergency room....I did not know if s/he was actually dead when I left the emergency department". Despite the comments made by Registrar #1, neither Nurse #1 or Nurse #2 went to assess Patient #1. Nurse #2 confirmed s/he saw Registrar #1 enter bay #11 and described Registrar #1 as s/he was walking out from bay #11 as ".... nervous" and "...said I think s/he's dead". Nurse #2 stated at the time of interview that " I said s/he was moving. She was sleeping. I did not go up to look at her/him....I know I should have but I didn't". Within 1-2 minutes after the Registrar's reported observations of Patient #1, Nurse #3, who was unaware of comments and concerns raised by Registrar #1, walked by bay #11 and glanced at Patient #1. Per interview on 10/7/13 at 3:15 PM, Nurse #3 stated "...s/he did not look well at all...s/he was not on a heart monitor, checked for a pulse...". Nurse described the pulse as "faint" and waved for Nurse #2, who was sitting at the nurses station, to come to bay #11. Per nursing note written by Nurse #1 at 2327, "...RN walked by Pts. room, noted Pt. to appear cyanotic, Pt. found to be pulseless and apnic (not breathing), CPR initiated". Resuscitation for cardiac arrest continued for 20 minutes. Patient's condition did not improve, the code was ended and time of death was noted to be 2351. Per interview on 10/8/13 at 10:18 AM, the Supervisor for Access Services, who oversees registration of patients receiving treatment in the	A 144		

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A 144	Continued From page 7 ED, stated s/he was informed by a member in the Access Services that Registrar #1 was upset after reporting to a nurse on the night of 9/24/13 that upon entering bay #11 s/he noted the patient appeared dead, but the nurse "blew her off". When the Supervisor for Access Services was asked about the relationship between Access Service staff and ED nursing staff, s/he reported there have been past issues between departments when staff conducting ED registration have alerted nursing of a immediate concern related to a patient seeking ED services and the response from nursing was the	A 144		
A 145	Registrars were "..over reacting...". 482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure all patients seeking treatment are free from neglect for 1 applicable patient. (Patient #1) The facility failed to report within 48 hours allegations of abuse to Adult Protective Services in accordance with Vermont State Statute Title 33 Chapter 69 "Reports of abuse, Neglect and Exploitation of Vulnerable Adults". Findings include: On the night of 9/24/13 2 nurses assigned to work in the ED demonstrated indifference and neglect when notified by a hospital employee that a newly admitted patient to the ED demonstrated a change in condition. Both nurses failed to respond when alerted the patient appeared dead and demonstrated disregard for the patient's	A 145	**Tag A 145** Background information: The Hospital acknowledges the care deficiencies that were cited but notes that in the Statement of Deficiencies (page 22 of 27), it is stated that Nurse #3 described the patient's pulse as "faint". Respectfully, the Hospital reports that Nurse #3 has confirmed that it is not her/his recollection that the patient's pulse was "faint"; rather, it is her/his recollection upon entering bay #11 and glancing at the patient that s/he believed that the patient was deceased, which s/he recalls was confirmed by her/his physical exam of the patient. The Hospital would also like to clarify that the first notice to the State Agency/Adult Protective Services occurred by telephone by leaving a voice message on Wednesday, October 2, 2013, at approximately 5:45 pm.	10/17/13

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A 145	Continued From page 8 emergent needs and condition by describing the patient as" playing possum". Patient #1 arrived via ambulance to the Emergency Department (ED) on 9/24/13 at 23:07. Patient #1 had multiple co-morbidities to include: Type 2 Diabetes mellitus; Epilepsy with severe seizure disorder; End Stage Renal Disease (ESRD) requiring dialysis treatments 3 x per wk; sleep apnea; asthma, obesity, hypothyroidism and Bipolar disorder. Per Emergency Medical Services (EMS)/Rescue Squad "Prehospital Care Report" for 9/24/13 at 22:30, Patient #1 was complaining of severe back pain, relating it to a fall which occurred on 9/14/13 and a recent cortisone injection. The report also noted Patient #1 was observed to have "...dry heaves...complained of stomach pain....s/he is short of breath...starting to breath rapidly...Also having some chest pain...Pt put on 3 lit (liters) of 02 (oxygen) nasal canula pt noting that O2 did help with breathing". Per interview on 10/8/13 at 11:40 AM, a Advanced EMT #1 (Emergency Medical Technician) who was part of Patient #1's transport team to the ED on 9/24/13 confirmed the patient was anxious. EMT #1 stated because of Patient #1's presenting symptoms to include continuous low blood pressure readings (85/60, 84/54. & 76/56) and the inability to establish an IV, the Paramedic was requested to arrive at the scene for assistance. EMT #1 also stated Patient #1 was placed on a 4 lead cardiac monitor but frequent artifact was noted due to the patient's restless movement, discomfort and anxiety. Upon arrival to the ED, EMS removed the monitor and discontunued the oxygen. Per interview on 10/7/13 at 1:58 PM, Nurse #1 confirmed she had obtained a report from EMS	A 145	**Tag A145 (cont'd)** Plan for Correction: An educational presentation entitled Patient Safety, Communication and Privacy: An Impact on Outcomes, which includes the module entitled *Delivery of Care When Patient Rights were Compromised*, was presented in a live, interactive event for staff from the Emergency Department (nursing, physicians, technicians and unit secretaries) and by a written module to remaining members of the ED, Access Services and the Security departments. This module provided specific focus on patient's rights and protection from abuse and neglect and the reporting requirements. The Hospital's policy on Abuse, Neglect and Exploitation of a Vulnerable Adult was revised. Education is being provided to ED, Access Services and Security departments on the standards, process and expectations for reporting abuse, neglect or exploitation. The Hospital's event reporting system was revised to provide that an event report be filed every time a report is made to a state agency related to abuse, neglect or exploitation; this will permit a uniform system to review the timeliness of reports. Implementation: 100% of staff members in the Emergency Department, Emergency Medicine, Access Services and Security departments are required to complete a written or online test on the Patient Safety, Communication and Privacy: An Impact on Outcomes training. As of October 25, 2013, the following staff have completed the training: • ED RNs: 97% (31/32) • ED physicians: 93% (14/15) • ED Technicians/unit secretaries, ~~Access~~ and Security staff: 100% • Access 90% (18/20) The remaining two staff members are on medical leave and will not be permitted to return to duty until the competency has been completed. The understanding	10/24/13 10/23/13 10/29/13 10/22/13 10/24/13 10/29/13

10/24/13
2 Access
1 Bereavement LOA
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A 145	Continued From page 9 regarding Patient #1 to include back pain, shortness of breath and stomach pain. "She was yelling...appeared to be in quite a bit of pain". Nurse #1 rated the patient's pain to be a "10" (on a 1-10 pain scale/10 being the worse level of pain) but noted Patient #1 did not answer Nurse #1's questions during the Triage process stating the patient was yelling in pain. At the completion of the Triage process that was conducted on the opposite side of the large trauma bay, Nurse #1 left the area. No direction was provided by Nurse #1 to other ED staff to place Patient #1 on a cardiac monitor or apply oxygen. The only vital signs recorded, taken by the ED technician, included: B/P 130/96, pulse 88 and oxygen level via pulse oximeter was reported at 96 on room air. Nurse #1 acknowledged s/he was aware of Patient #1 from past ED visits and acknowldeged "..s/he often needs everything....and it takes extra time..." during the provision of care. In addition, Nurse #1 confirmed Patient #1 should have been placed on a cardiac monitor upon admission to bay #11. Nurse #2, who was assigned to Patient #1, sat at the nurses station located opposite trauma bay #11 and observed Patient #1's arrival by EMS. Per interview on 10/7/13 at 12:01 PM, Nurse #2 stated s/he was on the computer and did not get up to assist staff and EMS with the patient's transfer or assess the patient's physical status once the ED technician had completed vital signs. Nurse #2 stated " ...the patient was crying out in pain...I continued my charting". Nurse #1 stated staff had dimmed the lights in bay #11 to "...make the patient more comfortable...I would glance over to see her/him move their arm or leg". Nurse #2 did not direct ED technician to place the patient on a cardiac monitor, nor was an attempt	A 145	**Tag A145 (cont'd)** of this education will be assessed by obtaining a passing score on a written or online test. All new staff will be provided the same material as a component of their orientation program.	Ongoing
			Education on the policy changes for Abuse, Neglect and Exploitation of Vulnerable Adults and event reporting requirement was provided to 100% of Hospital Directors on Wednesday, October 23, 2013. The Directors and their designated leadership staff members shall provide direct, one-on-one education with staff on the changes to the policy, which is documented and tracked via a sign-off sheet. To assess and validate staff knowledge of this education, Directors will review this competency in one-on-one meetings with their direct reports. After October 29, 2013, any staff members in Emergency Department, Access Services and Security department who have not completed this training will not be permitted to return to duty until the competency has been completed.	10/23/13 Ongoing Ongoing 10/29/13
			Monitoring: Emergency Department, Access Services and Security department leadership will conduct regular, one-on-one meetings ("rounding on staff") with all employees to assess their competency with recognizing vulnerable adults and the required reporting requirements, including the need for filing an report. Any lack of understanding or noncompliance identified in these meetings abuse, neglect and exploitation of event will be immediately and directly addressed with the staff member through the Hospital's Corrective Action policy.	Ongoing

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A 145	Continued From page 10 made to achieve IV access or to address and reassess the patient's complaints of pain. Patient #1 was left alone. At approximately 10 minutes after admission to the ED between 2220-2224 on 9/24/13 Access Services Registrar #1 entered bay #11 to complete the registration process, verify information and obtain a signature for treatment from Patient #1. Per telephone interview on 10/7/13 at 4:00 PM. Registrar #1 stated "I spoke to her/him a couple of times (Patient #1)...her/his head was to the side and her/his mouth was open. There was no response from her/his eyes. I was quite close to her/him. I was up by her/his head. I looked at her/his chest area to see if there was any movement." Registrar #1 reported s/he quickly went to the end of the trauma bay area and "I said to the nurses who were nearby. I said she/he (Patient #1) is dead. One of the nurses said 'oh s/he's playing possum'.....'I'll sign your papers for her/him'....She signed my paper and at that point I left the emergency room....I did not know if s/he was actually dead when I left the emergency department". The nurse who described Patient #1 as "playing possum" was later identified by Registrar #1 as Nurse #1. Despite the comments made by Registrar #1, neither Nurse #1 or Nurse #2 went to assess Patient #1. Nurse #2 confirmed s/he saw Registrar #1 enter bay #11 and described Registrar #1 as s/he was walking out from bay #11 as ".... nervous" and "...said I think s/he's dead". Nurse #2 stated at the time of interview " I said s/he was moving. She was sleeping. I did not go up to look at her/him....I know I should have but I didn't". Verification of comments made by Nurse #1 to Registrar #1 were denied, and at	A 145	**Tag A145 (cont'd)** Patients with three or more visits over the last 60 days will be identified via a daily report and the ED nursing leadership (or other designated RN) will conduct chart audits of 100% of such encounters to assure that appropriate care was provided and there was no abuse or neglect occurring. This monitoring will occur each business day (with weekend encounters reviewed on the following Monday) for a period of at least ninety days, the results of which will be assessed as part of the hospital QA/PI program. The reviewer will notify the department manager of any deviations identified for immediate follow up. The results of this monitoring will be reported to the Administrative Safety Quality Committee monthly, which minutes are reported to and reviewed by the Board Safety Quality Committee. Beginning October 25, 2013, the Corporate Compliance Officer will provide monitoring of 100% of state reported events for compliance with the state law requirements. This monitoring will be in the form of a review of 100% of event reports filed in the category of "State Report Filed". This monitoring will occur weekly to ensure compliance and will provide correction and additional education as deviations are identified. The results of this monitoring will be reported to the Executive Compliance Committee each quarter and subsequently to the Board level Audit and Compliance Committee. Executive Responsible: Chief Nursing Officer.	10/28/13 Ongoing Ongoing Ongoing

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A 145	Continued From page 11 the time of interview, Nurse #1 stated Nurse #2 made the sarcastic comment. However within 1-2 minutes after the Registrar's reported observations of Patient #1, Nurse #3, who was unaware of comments and concerns raised by Registrar #1, walked by bay #11 and glanced at Patient #1. Per interview on 10/7/13 at 3:15 PM, Nurse #3 stated "...s/he did not look well at all...s/he was not on a heart monitor, checked for a pulse...". Nurse #3 described the pulse as "faint" and waved for Nurse #2, who continued sitting at the nurses station, to come to bay #11. Per nursing note written by Nurse #1 at 2327, "...RN walked by Pts. room, noted Pt. to appear cyanotic, Pt. found to be pulseless and apnic (not breathing), CPR initiated ". Resuscitation for cardiac arrest continued for 20 minutes. Patient's condition did not improve, the code was ended and time of death was noted to be 2351. In addition, the hospital failed to report the adverse event involving ED nursing staff and Patient #1 within the required 48 hours per Vermont State Statute Title 33 Chapter 69 "Reports of Abuse, Neglect and Exploitation of Vulnerable Adults. Although individual hospital staff, who are mandated reporters, were intially informed beginning on 9/26/13 of events surrounding the unexpected death of Patient #1 on 9/24/13, and Administrative staff to include Risk Mangement and Patient Safety and Quality were fully informed of the adverse event on 10/1/13, voice mail notification to the State Agency/Adult Protective Services did not occurr until 10/3/13 at 5:41 PM (after hours) stating only there had been a complaint related to ED services made by an employee.	A 145		
A 147	482.13(d)(1) PATIENT RIGHTS:	A 147	**Tag A 147** Plan for Correction: The Hospital's Privacy Officer reviewed the Confidentiality of Information policy and found that it was compliant so no additional changes were made. However, in accordance with such policy, a disclosure was made to the family members of Patient 1 to advise them of this privacy violation and to apologize. Following that verbal disclosure and apology, a letter was sent to the health care proxy for the patient from the Privacy Officer on October 16, 2013. This letter advised of the reporting and grievance procedures in instances of a privacy violation.	10/16/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 147	Continued From page 12 CONFIDENTIALITY OF RECORDS The patient has the right to the confidentiality of his or her clinical records. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to assure the patient's right to the confidentiality of his or her clinical records were maintained for 1 applicable patient. (Patient #1) Findings include: During the course of the investigation regarding care and services not provided to Patient #1 on the evening of 9/24/13 it was reported a call had been made to EMS shortly after the patient's expired to report the death to EMS personnel. Per interview on 10/8/13 at 11:40 AM, EMT #1 stated "The hospital called the rescue squad, said that s/he had passed". Per interview on 10/8/13 at 12:59 PM ED Technician #1 stated s/he had overheard a discussion by EMS staff regarding Patient #1's presenting symptoms and whether the symptoms were cardiac related. S/he also onfirmed shortly after Patient #1 expired a nurse made a call to EMS/Rescue Squad office to notify them the patient had expired. When asked if this is routine ED policy and procedure to make such	A 147	**Tag A147 (cont'd)** The Hospital's leadership team is committed to the protection of patient privacy and will incorporate privacy monitoring in their daily rounding as reflected on modification to the Senior Leader Rounding Tool. Implementation: An educational presentation entitled Patient Safety, Communication and Privacy: An Impact on Outcomes, which includes a module entitled *HIPAA and the Emergency Department*, was developed and presented to staff from the Emergency Department (nursing, physicians, technicians and unit secretaries), Access Services department and Security department. 100% of staff of all these departments will complete this training. As of October 25, 2013, the following staff have completed the training: • ED RNs: 97% (31/32) • ED physicians: 93% (14/15) • ED Technicians/unit secretaries, ~~Access~~ and Security staff: 100% 10/24/13 Access 90% (18/20) The remaining two staff members are on medical leave and will not be permitted to return to duty until the training has been completed. The understanding of this education will be assessed by obtaining a passing score on a written or online test. All new staff will be provided the same material as a component of their orientation program.	10/21/13 10/24/13 1 on bereavement LOA and 1 out of area, 10/29/13 Ongoing
A 263	a phone call, the ED Technician stated it was not. 482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that	A 263	Monitoring: Patient confidentiality including verbal communications will be monitored by the Executive leadership team and the department leadership as a part of the Hospital's existing daily rounding program; corrections will be provided to staff when observed and provided to managers for review according to the Corrective Action policy. Any breaches identified will be reported to the Privacy Officer via the Hospital's event reporting system and will	10/21/13 Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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A 263	a phone call, the ED Technician stated it was not. 482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement prDgram. The hospital's governing body must ensure that	A 263	The RCA team completed its investigation and presented its findings on October 22, 2013 to the Sentinel Event Oversight committee. Pursuant to the Hospital's Sentinel Event procedure, the RCA findings and action plan will be submitted to the Administrative Safety Quality Committee on October 29, 2013. Their minutes will be forwarded to the Board Safety Quality Committee for review at the meeting scheduled on November 18, 2013, which will monitor plan implementation until it is completed. On October 18, 2013, the Code Committee performed a review of the patient's code team response. The Code Committee reviews all codes to determine if they met	10/22/13 10/29/13 Ongoing 10/20/13

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A 263	Continued From page 13 the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the Condition of Participation for Quality Assessment and Performance Improvement (QA/PI) was not met due to the hospital's failure to initiate immediate interventions to ensure patient safety. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. Refer to Tags: A-286	A 263	**Tag A263 (cont'd)** the ACLS standards of care. The Medical Director of the Emergency Department discussed the review with the providers involved on October 20, 2013. To prevent delays in launching a root cause analysis, the Patient Safety and Quality Department established a set of internal guidelines for department staff to start the RCA process within 48 hours of a serious reportable event. Identification of Serious Reportable Events: Hospital policies and procedures were reviewed and revised to assure that they were sufficient in establishing expectations and procedures for guiding hospital personnel in responding to such events. These policies include the Sentinel Event Procedure, Reporting of Unsafe Acts Policy, Adverse Event Policy and the guide for performing a root cause analysis. 100% of staff in the Emergency Department and Access Services completed a "Net Learning" training on "Serious Reportable Events". This same module is part of the annual mandatory education program for all staff. The module outlines how to identify a serious patient event, the need to immediately (during their current shift) report the event to a supervisor and to the Patient Safety and Quality Department, and tips on how to do so. Reporting Serious Adverse Events: An educational campaign called "*PR: Prevent & Report*" was provided to 100% of Hospital Directors on Wednesday, October 23, 2013. The Directors shall provide direct, one-on-one education with staff on this program, which is documented and tracked via a sign-off sheet. To assess and validate staff knowledge of this education, Directors will review this competency in one-on-one meetings with their direct reports.	10/23/13 10/22/13 10/24/13 10/23/13 Ongoing
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities	A 286		

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A 263	Continued From page 13 the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the Condition of Participation for Quality Assessment and Performance Improvement (QA/PI) was not met due to the hospital's failure to initiate immediate interventions to ensure patient safety. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. Refer to Tags: A-286	A 263	**Tag A263 (cont'd)** Revisions to the Hospital's event reporting system were made to provide easier reporting and more streamlined review. Education on this change was provided to 100% of Hospital Directors on Wednesday, October 23, 2013. The Directors shall provide direct, one-on-one education with staff on these changes, which is documented and tracked via a sign-off sheet. To assess and validate staff knowledge of this education, Directors will review this competency in one-on-one meetings with their direct reports. Implementation: The Hospital's Reporting of Unsafe Acts Policy, Adverse Event Policy, Sentinel Event Procedure and Event and Quality Reporting Policy were revised. Education on the policy changes was provided to 100% of Hospital Directors on Wednesday, October 23, 2013. The Directors shall provide direct, one-on-one education with staff on the changes to the policies, which is documented and tracked via a sign-off sheet. To assess and validate staff knowledge of this education, Directors will review this competency in one-on-one meetings with their direct reports.	10/22/13 Ongoing 10/22/13 10/23/13 Ongoing
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities	A 286	All Directors, Clinical Coordinators, Designees participated in an educational campaign called "PR: Prevent & Report" to review identification and reporting requirements as well as requirements for taking immediate action to assure patient safety within the unit and throughout the hospital as soon as an event occurs. As of October 25, 2013, 97% (87/90) Directors, Clinical Coordinators and Designees have been trained; the remaining three are out of the area or on medical leave and will not be permitted to return to duty until the competency has been completed.	10/25/13

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A 263	Continued From page 13 the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the Condition of Participation for Quality Assessment and Performance Improvement (QA/PI) was not met due to the hospital's failure to initiate immediate interventions to ensure patient safety. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. Refer to Tags: A-286	A 263	**Tag A263 (cont'd)** The understanding and competency of this education was assessed by obtaining a passing score on a written test; any staff members who did not pass the test were re-trained and tested again to demonstrate they understand the policy changes. This was documented and tracked via a sign-off sheet. The Directors and Clinical Coordinators shall provide direct, one-on-one education with their staff on this campaign. To assess and validate staff understanding of this education, Directors and Clinical Coordinators will review this competency in one-on-one meetings with their direct reports. The Patient Safety and Quality Department established a set of guidelines and a checklist to ensure that a Root Cause Analysis is initiated within 48 hours of a serious reportable event. The guidelines and checklist will be used internally by the individual in the department who is first alerted to the fact that a serious reportable event has occurred. Included in the guidelines is a check-off to convene the Sentinel Event Oversight Team within 48 hours of learning of an adverse event. Quality Department staff were educated on the change and the expectation on October 23, 2013. The checklist was attached to the Adverse Event Policy and Root Cause Analysis form.	10/25/13 Ongoing 10/23/13
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities	A 286	An educational presentation entitled Patient Safety, Communication and Privacy: An Impact on Outcomes was developed and presented to staff from the Emergency Department (nursing, technicians, unit secretaries and physicians), Access Services department and the Security	10/24/13

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A 263	Continued From page 13 the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the Condition of Participation for Quality Assessment and Performance Improvement (QA/PI) was not met due to the hospital's failure to initiate immediate interventions to ensure patient safety. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. Refer to Tags: A-286	A 263	**Tag A263 (cont'd)** department. The specific modules presented, as reflected in the Communication and Education Plan, are *Culture of Safety, Communicating for Outcomes, HIPAA and the Emergency Department,* and *Delivery of Care when Patient Rights were Compromised.* This education focused directly on patients' right to safe care and how each employee can and must live the Hospital's Culture of Safety (C.A.R.I.N.G.). The sessions included experiential learning opportunities, small group work and a frank and direct discussion of the specific patient event at issue. Monitoring: To better identify potential adverse events, the Administrative Director of Patient Safety and Quality (or designee) will conduct on each business day (weekends and holidays will be reviewed on the next business day) monitoring of the following events to ensure that there are no failures to report events: • urgent and emergent operating room add-ons • unplanned ICU admissions • deaths in the hospital and Emergency Department Beginning on October 28, 2013, all of the above will be reviewed to ensure that reporting requirements were met and that immediate action was taken to prevent patient harm. In addition, the Administrative Director of Patient Safety and Quality (or designee) will notify managers within one business day of deviations that require corrective action and staff education about reporting requirements. Directors will be reminded to investigate to determine if immediate corrective actions are required. The results of this monitoring will be reported to the Administrative Safety Quality Committee each quarter, which minutes are reported to and reviewed by the Board Safety Quality Committee.	10/28/13 Ongoing
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities	A 286		

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A 263	Continued From page 13 the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the Condition of Participation for Quality Assessment and Performance Improvement (QA/PI) was not met due to the hospital's failure to initiate immediate interventions to ensure patient safety. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. Refer to Tags: A-286	A 263	**Tag A263 (cont'd)** The Administrative Director of Patient Safety and Quality (or designee) will perform daily reviews of all patient-related event reports for compliance with state and federal reporting requirements, that immediate action was taken to prevent patient harm, that an RCA was initiated within 48 hours and that correction, reporting and remedial education is provided to staff when deviations are identified. The results of this monitoring will be reported to the Administrative Safety Quality Committee each quarter, which minutes are reported to and reviewed by the Board Safety Quality Committee. Executive Responsible: Chief Medical Officer. **Tag A 286** **Note:** Please accept the response to Tag 263 in response to Tag 286, repeated below. Plan for Correction:	10/28/13
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities	A 286	Root Cause Analysis and Case Review: The Sentinel Event Oversight Team, comprised of the Chief Nursing Officer, Administrative Director of Patient Safety and Quality, Risk Manager, Chief Medical Officer, Administrative Director of the Inpatient Services Department, Patient Advocate and Medical Director of the Emergency Department, met to ensure the event had been 1) reported to appropriate state and regulatory agencies, 2) to ensure the hospital met its obligations for disclosure to the patient's family, and 3) to sanction a root cause analysis team to investigate the event, determine the root causes and develop a corrective action plan to address identified root causes. The RCA team completed its investigation and presented its findings on October 22, 2013 to the Sentinel Event Oversight committee. Pursuant to the Hospital's Sentinel Event procedure, the RCA findings	10/10/13 10/22/13 10/29/13

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A 286	Continued From page 14 (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital QA/PI program failed to implement timely preventative actions to assure patient safety throughout the hospital after an adverse patient event had occurred involving 1 applicable patient. (Patient #1) Findings include: Per interview on 10/7/13 at 9:55 AM, the Administrative Director for Patient Safety and Quality confirmed the Administrative staff was made aware on 10/1/13 of an adverse patient event which occurred on the night of 9/24/13 when 2 RN's employed in the ED demonstrated indifference and neglect when notified by a hospital employee that a newly admitted patient to the ED demonstrated a change in condition. Both nurses failed to respond when alerted the patient appeared dead and demonstrated disregard for the patient's emergent needs and condition by describing the patient as" playing	A 286	**Tag A286 (cont'd)** and action plan will be submitted to the Administrative Safety Quality Committee on October 29, 2013. Their minutes will be forwarded to the Board Safety Quality Committee for review at the meeting scheduled on November 18, 2013, which will monitor plan implementation until it is completed. On October 18, 2013, the Code Committee performed a review of the patient's code team response. The Code Committee reviews all codes to determine if they met the ACLS standards of care. The Medical Director of the Emergency Department discussed the review with the providers involved on October 20, 2013. To prevent delays in launching a root cause analysis, the Patient Safety and Quality Department established a set of internal guidelines for department staff to start the RCA process within 48 hours of a serious reportable event. Identification of Serious Reportable Events: Hospital policies and procedures were reviewed and revised to assure that they were sufficient in establishing expectations and procedures for guiding hospital personnel in responding to such events. These policies include the Sentinel Event Procedure, Reporting of Unsafe Acts Policy, Adverse Event Policy and the guide for performing a root cause analysis. 100% of staff in the Emergency Department and Access Services completed a "Net Learning" training on "Serious Reportable Events". This same module is part of the annual mandatory education program for all staff. The module outlines how to identify a serious patient event, the need to Immediately (during their current shift) report the event to a supervisor and to the Patient Safety and Quality Department, and tips on how to do so.	Ongoing 10/20/13 10/23/13 10/22/13 10/24/13

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A 286	Continued From page 15 possum". Upon learning of the adverse event, which included the death of the patient, the hospital administrative staff placed 2 nurses on suspension. An investigation of the event was initiated with interviews conducted of staff working on the night of 9/24/13. Per interview on 10/7/13 at 10:50 AM the Administrative Director for Inpatient Services confirmed the ED Nurse Manager had not begun any general discussions with staff regarding the incident or expectations regarding patient safety, care and services or patient rights. When the surveyor sought assurance that the hospital has implemented preventive actions and mechanisms that include feedback and learning throughout the hospital in order to prevent a similar incident from occurring, the Clinical Nurse Specialist for the ED stated on 10/7/13 at 10:56 AM since the adverse event "We have not done anything different. We provide quality care in the ED on a daily basis....if there are issues they are addressed, as this will be". However, the Clinical Nurse Specialist, who was also acting as ED Nurse Manager due to illness of the designated Nurse Manager, had not reviewed Patient #1's ED record to identify any QA/PI concerns. Additional concerns regarding implementing expedient action in response to the adverse patient event was also reviewed by the surveyor on 10/8/13. Per interview on 10/8/13 at 9:08 AM the Administrative Director - Compliance Officer, Administrative Director Inpatient Services and ED Clinical Nurse Specialist, confirmed nursing staff had still not been "spoken to" nor preventive actions identified and implemented. The internal investigation was continuing, however a Root Cause Analysis had been postponed due to the surveyors arrival and a review of the code in the	A 286	**Tag A286 (cont'd)** Reporting Serious Adverse Events: An educational campaign called "*PR: Prevent & Report*" was provided to 100% of Hospital Directors on Wednesday, October 23, 2013. The Directors shall provide direct, one-on-one education with staff on this program, which is documented and tracked via a sign-off sheet. To assess and validate staff knowledge of this education, Directors will review this competency in one-on-one meetings with their direct reports. Revisions to the Hospital's event reporting system were made to provide easier reporting and more streamlined review. Education on this change was provided to 100% of Hospital Directors on Wednesday, October 23, 2013. The Directors shall provide direct, one-on-one education with staff on these changes, which is documented and tracked via a sign-off sheet. To assess and validate staff knowledge of this education, Directors will review this competency in one-on-one meetings with their direct reports. Implementation: The Hospital's Reporting of Unsafe Acts Policy, Adverse Event Policy, Sentinel Event Procedure and Event and Quality Reporting Policy were revised. Education on the policy changes was provided to 100% of Hospital Directors on Wednesday, October 23, 2013. The Directors shall provide direct, one-on-one education with staff on the changes to the policies, which is documented and tracked via a sign-off sheet. To assess and validate staff knowledge of this education, Directors will review this competency in one-on-one meetings with their direct reports. All Directors, Clinical Coordinators, Designees participated in an educational campaign called "PR: Prevent & Report" to review identification and reporting requirements as well as requirements for taking immediate action to assure patient	10/23/13 Ongoing 10/22/13 Ongoing 10/22/13 10/23/13 Ongoing 10/25/13

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A 286	Continued From page 16 ED on 9/24/13 had not been reviewed by the Code Committee. Per interview on 10/8/13 at 4:30 PM, the Administrative Director- Compliance Officer subsequently reported that as of the afternoon of 10/7/13, 7 days since being made aware of the adverse patient event and after the arrival of surveyors, communication had now begun with nursing staff. The Administrative Director of Outpatient Services had initiated individual counseling, increasing staff awareness regarding the "Culture of Safety" and ensuring accountability. A nursing leadership meeting had transpired and mechanisms were being put in place and "action plans" formulated.	A 286	**Tab A286 (cont'd)** safety within the unit and throughout the hospital as soon as an event occurs. As of October 25, 2013, 97% (87/90) Directors, Clinical Coordinators and Designees have been trained; the remaining three are out of the area or on medical leave and will not be permitted to return to duty until the competency has been completed. The understanding and competency of this education was assessed by obtaining a passing score on a written test; any staff members who did not pass the test were re-trained and tested again to demonstrate they understand the policy changes. This was be documented and tracked via a sign-off sheet.	10/25/13
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on staff interview and record review the Condition of Participation: Nursing was not met as evidenced by the failure of Nursing staff to maintain standards of nursing practice during the provision of care and failed to respond when notified of a change in a patient's condition. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. A RN must supervise the nursing care for each patient. A RN must evaluate the care for each	A 385	The Directors and Clinical Coordinators shall provide direct, one-on-one education with their staff on this campaign. To assess and validate staff understanding of this education, Directors and Clinical Coordinators will review this competency in one-on-one meetings with their direct reports. The Patient Safety and Quality Department established a set of guidelines and a checklist to ensure that a Root Cause Analysis is initiated within 48 hours of a serious reportable event. The guidelines and checklist will be used internally by the individual in the department who is first alerted to the fact that a serious reportable event has occurred. Included in the guidelines is a check-off to convene the Sentinel Event Oversight Team within 48 hours of learning of an adverse event. Quality Department staff were educated on the change and the expectation on October 23, 2013. The checklist was attached to the Adverse Event Policy and Root Cause Analysis form. An educational presentation entitled Patient Safety, Communication and Privacy: An Impact on Outcomes was developed and presented to staff from the Emergency	Ongoing 10/23/13 10/24/13

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A 286	Continued From page 16 ED on 9/24/13 had not been reviewed by the Code Committee. Per interview on 10/8/13 at 4:30 PM, the Administrative Director- Compliance Officer subsequently reported that as of the afternoon of 10/7/13, 7 days since being made aware of the adverse patient event and after the arrival of surveyors, communication had now begun with nursing staff. The Administrative Director of Outpatient Services had initiated individual counseling, increasing staff awareness regarding the "Culture of Safety" and ensuring accountability. A nursing leadership meeting had transpired and mechanisms were being put in place and "action plans" formulated.	A 286	**Tag A286 (cont'd)** Department (nursing, technicians, unit secretaries and physicians), Access Services department and the Security department. The specific modules presented, as reflected in the Communication and Education Plan, are *Culture of Safety, Communicating for Outcomes, HIPAA and the Emergency Department,* and *Delivery of Care when Patient Rights were Compromised.* This education focused directly on patients' right to safe care and how each employee can and must live the Hospital's Culture of Safety (C.A.R.I.N.G.). The sessions included experiential learning opportunities, small group work and a frank and direct discussion of the specific patient event at issue.	
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on staff interview and record review the Condition of Participation: Nursing was not met as evidenced by the failure of Nursing staff to maintain standards of nursing practice during the provision of care and failed to respond when notified of a change in a patient's condition. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. A RN must supervise the nursing care for each patient. A RN must evaluate the care for each	A 385	Monitoring: To better identify potential adverse events, the Administrative Director of Patient Safety and Quality (or designee) will conduct on each business day (weekends and holidays will be reviewed on the next business day) monitoring of the following events to ensure that there are no failures to report events: • urgent and emergent operating room add-ons • unplanned ICU admissions • deaths in the hospital and Emergency Department Beginning on October 28, 2013, all of the above will be reviewed to ensure that reporting requirements were met and that immediate action was taken to prevent patient harm. In addition, the Administrative Director of Patient Safety and Quality (or designee) will notify managers within one business day of deviations that require corrective action and staff education about reporting requirements. Directors will be reminded to investigate to determine if immediate corrective actions are required. The results of this monitoring will be reported to the Administrative Safety Quality Committee each quarter, which minutes are	10/28/13 Ongoing

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A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on staff interview and record review the Condition of Participation: Nursing was not met as evidenced by the failure of Nursing staff to maintain standards of nursing practice during the provision of care and failed to respond when notified of a change in a patient's condition. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. A RN must supervise the nursing care for each patient. A RN must evaluate the care for each	A 385	Emergency Department. This new template ensures that all essential elements of an EMS to triage nurse transfer of care will be obtained and addressed as well as documented. Completion of this template is required in 100% of patients who arrive by EMS. The Hospital policies entitled Delivery of Care and Nursing Responsibilities were revised to better maintain standards of nursing practice during the provision of care and to include a new provision requiring that patients be reassessed for any reported change in condition. Implementation: Management and oversight changes: • A new Emergency Department (ED) Nursing Director was placed into the unit effective October 9, 2013. • The oversight path for the Emergency Department nursing service was changed to reassign that service line to the Administrative Director of Inpatient Services (removing the former Administrative Director of Outpatient Services from this oversight responsibility). A new level of oversight over the ED charge nurse ("Designee") was created; the Clinical Coordinators now have	10/20/13 10/09/13 10/09/13 10/09/13

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SOUTHWESTERN VERMONT MEDICAL CENTER	100 HOSPITAL DRIVE BENNINGTON, VT 05201

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A 385	Continued From page 17 patient upon admission and when appropriate on an ongoing basis in accordance with accepted standards of nursing practice and hospital policy. Evaluation would include assessing the patient's care needs, patient's health status/conditioning, as well as the patient's response to interventions. Refer to A-0115, 0131; 0144; 0145; 0147; 0395	A 385	**Tag A385 (cont'd)** include a physical examination. This audit will also review the completion of the EMS handoff ("handover") protocol, which includes continuation of cardiac monitoring and oxygen on patient arrivals by Emergency Medical Services squads. This monitoring will occur each business day (with weekend encounters reviewed on the following Monday) for a period of at least	
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate he nursing care for each patient. This STANDARD is not met as evidenced by: Based on staff interview and record review, nursing staff failed to evaluate the care for each patient upon admission to the Emergency Department and when appropriate on an ongoing basis in accordance with accepted standards of nursing practice and hospital policy for 1 applicable patient . (Patient #1) Findings include: On the night of 9/24/13 2 nurses assigned to work in the ED demonstrated indifference and neglect when notified by a hospital employee that a newly admitted patient to the ED demonstrated a change in condition. Both nurses failed to respond when alerted the patient appeared dead and demonstrated disregard for the patient's emergent needs and condition by describing the patient as" playing possum". Per hospital policy Nursing Responsibilities revised 01/10 which pertains to the ED nursing staff states : "The scope of emergency nursing practice involves the assessment, analysis, nursing diagnosis, outcome identification,	A 395	ninety days, the results of which will be assessed as part of the Hospital's QA/PI program. The reviewer will notify the department manager of any deviations identified for immediate follow up. The results of this monitoring will be reported to the Administrative Safety Quality Committee monthly, which minutes are reported to and reviewed by the Board Safety Quality Committee. The ED nursing leadership or other designated RN will conduct chart audits of 100% of Emergency Department patient arrivals by EMS squads to validate for completion of the electronic documentation of the handoff ("handover"). This monitoring will occur each business day (with weekend encounters reviewed on the following Monday) for a period of at least ninety days, the results of which will be assessed as part of the Hospital's QA/PI program. The reviewer will notify the department manager of any deviations identified for immediate follow up. The results of this monitoring will be reported to the Administrative Safety Quality Committee, which minutes are reported to and reviewed by the Board. Patients with three or more visits over the last 60 days will be identified via a daily report and the ED nursing leadership (or other designated RN) will conduct chart audits of 100% of such encounters to assure that nursing standards of practice were met. This monitoring will occur each business day (with weekend encounters reviewed on the following Monday) for a period of at least ninety days, the results of	Ongoing 10/28/13 Ongoing 10/28/13

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A 385	Continued From page 17 patient upon admission and when appropriate on an ongoing basis in accordance with accepted standards of nursing practice and hospital policy. Evaluation would include assessing the patient's care needs, patient's health status/conditioning, as well as the patient's response to interventions. Refer to A-0115, 0131; 0144; 0145; 0147; 0395	A 385	**Tag A385 (cont'd)** which will be assessed as part of the Hospital's QA/PI program. The reviewer will notify the department manager of any deviations identified for immediate follow up. The results of this monitoring will be reported to the Administrative Safety Quality Committee monthly, which minutes are reported to and reviewed by the Board Safety Quality Committee.	Ongoing Ongoing
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate he nursing care for each patient. This STANDARD is not met as evidenced by: Based on staff interview and record review, nursing staff failed to evaluate the care for each patient upon admission to the Emergency Department and when appropriate on an ongoing basis in accordance with accepted standards of nursing practice and hospital policy for 1 applicable patient . (Patient #1) Findings include: On the night of 9/24/13 2 nurses assigned to work in the ED demonstrated indifference and neglect when notified by a hospital employee that a newly admitted patient to the ED demonstrated a change in condition. Both nurses failed to respond when alerted the patient appeared dead and demonstrated disregard for the patient's emergent needs and condition by describing the patient as" playing possum". Per hospital policy Nursing Responsibilities revised 01/10 which pertains to the ED nursing staff states : "The scope of emergency nursing practice involves the assessment, analysis, nursing diagnosis, outcome identification,	A 395	Executive Responsible: Chief Nursing Officer. **Tag A 395** **Note:** Please accept the response to Tag 385 in response to Tag 395, repeated below. Background information: The Hospital acknowledges the care deficiencies that were cited but notes that in the Statement of Deficiencies (page 22 of 27), it is stated that Nurse #3 described the patient's pulse as "faint". Respectfully, the Hospital reports that Nurse #3 has confirmed that it is not her/his recollection that the patient's pulse was "faint"; rather, it is her/his recollection upon entering bay #11 and glancing at the patient that s/he believed that the patient was deceased, which s/he recalls was confirmed by her/his physical exam of the patient. Plan for Correction: In response to learning of this incident, the two nurses involved in the care of the patient were removed from the provision of further care and have subsequently been terminated. A report to the Vermont Board of Nursing has been filed. The oversight of the nursing services in the Emergency Department was restructured to provide an additional layer of oversight and leadership resources available 24-hours per day. To immediately ensure patient safety in the Emergency Department, a schedule of supervision in the ED by nursing staff with strong leadership skills was implemented.	10/17/13 10/04/13 10/15/13 10/09/13 10/07/13

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A 395	Continued From page 18 planning, implementation of interventions, and evaluation of human responses to perceived, actual or potential, sudden or urgent, physical or psychosocial problems that are primarily episodic or acute, and which occur in a variety of settings. These may require minimal care to life-support measures; patient, family, and significant other education; appropriate referral and discharge planning; and knowledge of legal implications" Emergency Nurses Association Scope of Emergency Nursing practice. (July, 1999) Per Vermont Title 26: Professions and Occupations, Chapter 28: Nursing "Registered nursing" means the practice of nursing which includes: (A) Assessing the health status of individuals and groups; (H) Maintaining safe and effective nursing care rendered directly or indirectly (I) Evaluating responses to interventions; (L) Collaborating with other health professionals in the management of health care and (M) Addressing patient pain. However, per record review, Patient #1 arrived via ambulance to the Emergency Department (ED) on 9/24/13 at 23:07. Patient #1 had multiple co-morbidities to include: Type 2 Diabetes mellitus; Epilepsy with severe seizure disorder; End Stage Renal Disease (ESRD) requiring dialysis treatments 3 x per wk; sleep apnea; asthma, obesity, hypothyroidism and Bipolar disorder. Per Emergency Medical Services (EMS)/Rescue Squad "Prehospital Care Report" for 9/24/13 at 22:30, Patient #1 was complaining of severe back pain, relating it to a fall which occurred on 9/14/13 and a recent cortisone injection. The report also noted Patient #1 was observed to have "...dry heaves...complained of stomach pain....s/he is short of breath...starting to	A 395	**Tag A395** In addition, all staff members involved in any way with this incident are undergoing a performance review with determination of action plans. The ED charge nurse ("Designee") and ED RN performance expectations were revised to reflect responsibility for immediate response to a change in patient condition and report of inappropriate or unprofessional behavior. The expectations for the ED charge nurse ("Designee") and the Clinical Coordinator were also revised to reflect an increased leadership responsibility and new reporting line. The Hospital policy entitled Triage Nurse Roles and Responsibilities was revised to require that patients arriving on oxygen and/or cardiac monitoring have these continued until the physician evaluation has been completed. The Hospital has modified its electronic medical record to provide a new standardized template for taking and documenting handoffs ("handovers") from Emergency Medical Services ("EMS") members to the triage nurse in the Emergency Department. This new template ensures that all essential elements of an EMS to triage nurse transfer of care will be obtained and addressed as well as documented. Completion of this template is required in 100% of patients who arrive by EMS. The Hospital policies entitled Delivery of Care and Nursing Responsibilities were revised to better maintain standards of nursing practice during the provision of care and to include a new provision requiring that patients be reassessed for any reported change in condition. Implementation: Management and oversight changes: • A new Emergency Department (ED)	10/28/13 10/10/13 10/10/13 10/20/13 10/23/13 10/20/13 10/09/13

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A 395	Continued From page 18 planning, implementation of interventions, and evaluation of human responses to perceived, actual or potential, sudden or urgent, physical or psychosocial problems that are primarily episodic or acute, and which occur in a variety of settings. These may require minimal care to life-support measures; patient, family, and significant other education; appropriate referral and discharge planning; and knowledge of legal implications" Emergency Nurses Association Scope of Emergency Nursing practice. (July, 1999) Per Vermont Title 26: Professions and Occupations, Chapter 28: Nursing "Registered nursing" means the practice of nursing which includes: (A) Assessing the health status of individuals and groups; (H) Maintaining safe and effective nursing care rendered directly or indirectly (I) Evaluating responses to interventions; (L) Collaborating with other health professionals in the management of health care and (M) Addressing patient pain. However, per record review, Patient #1 arrived via ambulance to the Emergency Department (ED) on 9/24/13 at 23:07. Patient #1 had multiple co-morbidities to include: Type 2 Diabetes mellitus; Epilepsy with severe seizure disorder; End Stage Renal Disease (ESRD) requiring dialysis treatments 3 x per wk; sleep apnea; asthma, obesity, hypothyroidism and Bipolar disorder. Per Emergency Medical Services (EMS)/Rescue Squad "Prehospital Care Report" for 9/24/13 at 22:30, Patient #1 was complaining of severe back pain, relating it to a fall which occurred on 9/14/13 and a recent cortisone injection. The report also noted Patient #1 was observed to have "...dry heaves...complained of stomach pain....s/he is short of breath...starting to	A 395	**Tag A395 (cont'd)** Nursing Director was placed into the unit effective October 9, 2013. • The oversight path for the Emergency Department nursing service was changed to reassign that service line to the Administrative Director of Inpatient Services (removing the former Administrative Director of Outpatient Services from this oversight responsibility). A new level of oversight over the ED charge nurse ("Designee") was created; the Clinical Coordinators now have global oversight of all nursing responsibility which includes oversight of the ED Designee when the Department leader is not present. • The ED charge nurse ("Designee") and ED RN job descriptions were revised to reflect their responsibility for immediately responding to a change in patient condition and reporting all inappropriate or unprofessional behavior; all new job descriptions will be reviewed and signed by the staff member. • The new job descriptions for the ED Nursing Director, Administrative Director of Inpatient Services and Clinical Coordinators have been revised to reflect their increased leadership responsibility and reporting line; all will be reviewed and signed by the staff member. • All these individuals will be assessed against these new criteria at the time of their annual review pursuant to Hospital policy. • Nursing leadership and the Hospital's Human Resources Director have completed a review of the performance of all staff involved in this patient's care (either directly or through supervision). Corrective actions will be completed pursuant to the Hospital's Corrective Action policy and documented in the personnel records of all staff.	10/09/13 10/09/13 10/10/13 10/29/13 10/10/13 10/29/13 Ongoing 10/22/13 10/29/13

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A 395	Continued From page 19 breath rapidly...Also having some chest pain...Pt put on 3 lit (liters) of 02 (oxygen) nasal canula pt noting that O2 did help with breathing". Per interview on 10/8/13 at 11:40 AM, a Advanced EMT #1 (Emergency Medical Technician) who was part of Patient #1's transport team to the ED on 9/24/13 confirmed the patient was anxious. EMT #1 stated because of Patient #1's presenting symptoms to include continuous low blood pressure readings (85/60, 84/54. & 76/56) and the inability to establish an IV, the Paramedic was requested to arrive at the scene for assistance. EMT #1 also stated Patient #1 was placed on a 4 lead cardiac monitor but frequent artifact was noted due to the patient's restless movement, discomfort and anxiety. Per interview on 10/7/13 at 1:58 PM, Nurse #1, who was assigned to Triage on the evening of 9/24/13, confirmed upon Patient #1's arrival to the ED, s/he had obtained a report from EMS regarding Patient #1 to include back pain, shortness of breath and stomach pain. "S/he was yelling...appeared to be in quite a bit of pain". Nurse #1 further stated s/he had cared for Patient #1 in the past during previous ED visits. Nurse #1 rated the patient's pain to be a "10" (on a 1-10 pain scale/10 being the worse level of pain) but noted Patient #1 did not answer Nurse #1's questions during the Triage process stating the patient was yelling in pain. At the completion of the Triage process that was conducted on the opposite side of the large trauma bay, Nurse #1 left the area. No direction was provided by Nurse #1 to other ED staff to place Patient #1 on a cardiac monitor or apply oxygen. The only vital signs recorded, taken by the ED technician, included: B/P 130/96, pulse 88 and oxygen level via pulse oximeter was recorded as 96 on room	A 395	**Tag A395 (cont'd)** Policy/practice changes: The ED Clinical Nurse Specialist (or other designated RN) and have provided direct, one-on-one education with staff on the changes to the following policies: Triage Nurse Roles and Responsibilities, Delivery of Care and Nursing Responsibilities as well as EMS handoff ("handover") documentation requirement, which has been documented and tracked via a sign-off sheet. 100% of ED ~~and Access Services~~ staff have completed the training except for one RN on medical leave who will not be permitted to return to duty until the training has been completed. 10/3/13 The understanding of this education will be assessed by obtaining a passing score on a written or online test. The ED charge nurses ("Designees") will provide timely oversight of general nursing care and in particular, treatment of patient arrivals by Emergency Medical Services squads, for compliance with nursing care standards of practice. The Designee will provide direct in-person correction of any noncompliance and refer it to the ED Director to be addressed in conjunction with the Corrective Action policy. The Clinical Coordinator will round on each shift with the ED charge nurse ("Designee") to assess at risk patient populations, compliance with reporting where indicated, and adequacy of resources. Monitoring: Hospital leadership will conduct regular, one-on-one meetings ("rounding on staff") with all charge nurses ("Designees"), Clinical Coordinators, ED Director/Manager and Administrative Director of Inpatient Services to assess their competency in their increased roles. Any lack of understanding, noncompliance or performance issues	10/24/13 10/29/13 Ongoing Ongoing Ongoing

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A 395	Continued From page 20 air. At the time of interview, Nurse #1 stated s/he should have placed the patient on the monitor and paid more attention at the time of triage. Nurse #2, who was assigned to Patient #1, sat at the nurses station located opposite the trauma bay #11 and observed Patient #1's arrival by EMS. Per interview on 10/7/13 at 12:01 PM, Nurse #2 stated s/he was on the computer and did not get up to assist staff and EMS with the patient's transfer or assess the patient's physical status once the ED technician had completed vital signs. Nurse #2 stated " ...the patient was crying out in pain...I continued my charting". Nurse #1 stated staff had dimmed the lights in bay #11 to "...make the patient more comfortable...I would glance over to see her/him move their arm or leg". At approximately 10 minutes after admission to the ED between 2220-2224 on 9/24/13 Access Services Registrar #1 entered bay #11 to complete the registration process, verify information and obtain a signature for treatment from Patient #1. Per telephone interview on 10/7/13 at 4:00 PM. Registrar #1 stated "I spoke to her/him a couple of times (Patient #1)...her/his head was to the side and her/his mouth was open. There was no response from her/his eyes. I was quite close to her/him. I was up by her/his head. I looked at her/his chest area to see if there was any movement." Registrar #1 reported s/he quickly went to the end of the trauma bay area and "I said to the nurses who were nearby. I said she/he (Patient #1) is dead. One of the nurses said 'oh s/he's playing possum'....'I'll sign your papers for her/him'....She signed my paper and at that point I left the emergency room....I did not know if s/he was actually dead when I left the	A 395	**Tag A395 (cont'd)** identified will be immediately and directly addressed with the staff member through the Hospital's Corrective Action policy. The ED nursing leadership (or other designated RN) will conduct chart audits of 100% of Emergency Department patient encounters to validate compliance with the Triage, Delivery of Care and Nursing Responsibilities policies, specifically reviewing adequacy of response to pain and the requirement that the assessment by the nurse be conducted at the bedside and include a physical examination. This audit will also review the completion of the EMS handoff ("handover") protocol, which includes continuation of cardiac monitoring and oxygen on patient arrivals by Emergency Medical Services squads. This monitoring will occur each business day (with weekend encounters reviewed on the following Monday) for a period of at least ninety days, the results of which will be assessed as part of the Hospital's QA/PI program. The reviewer will notify the department manager of any deviations identified for immediate follow up. The results of this monitoring will be reported to the Administrative Safety Quality Committee monthly, which minutes are reported to and reviewed by the Board Safety Quality Committee. The ED nursing leadership or other designated RN will conduct chart audits of 100% of Emergency Department patient arrivals by EMS squads to validate for completion of the electronic documentation of the handoff ("handover"). This monitoring will occur each business day (with weekend encounters reviewed on the following Monday) for a period of at least ninety days, the results of which will be assessed as part of the Hospital's QA/PI program. The reviewer will notify the department manager of any deviations identified for immediate follow up. The results of this monitoring will	10/28/13 Ongoing 10/28/13 Ongoing

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A 395	Continued From page 21 emergency department". Despite the comments made by Registrar #1, both Nurse #1 or Nurse #2 failed to assess the health status of Patient #1. Nurse #2 confirmed s/he saw Registrar #1 enter bay #11 and described Registrar #1 as s/he was walking out from bay #11 as ".... nervous" and "...said I think s/he's dead". Nurse #2 stated at the time of interview that " I said s/he was moving. She was sleeping. I did not go up to look at her/him....I know I should have but I didn't". Within 1-2 minutes after the Registrar's reported observations of Patient #1, Nurse #3, who was unaware of comments and concerns raised by Registrar #1, walked by bay #11 and glanced at Patient #1. Per interview on 10/7/13 at 3:15 PM, Nurse #3 stated "...s/he did not look well at all...s/he was not on a heart monitor, checked for a pulse...". Nurse described the pulse as "faint" and waved for Nurse #2, who was sitting at the nurses station, to come to bay #11. Per nursing note written by Nurse #1 at 2327, "...RN walked by Pts. room, noted Pt. to appear cyanotic, Pt. found to be pulseless and apnic (not breathing), CPR initiated". Resuscitation for cardiac arrest continued for 20 minutes. Patient's condition did not improve, the code was ended and time of death was noted to be 2351. Per interview on 10/8/13 at 12:32 PM, the Medical Director for the ED stated s/he was made aware of the adverse patient event 1 week ago and remarked "a nurse making incredible poor judgement which may have delayed this patient having a chance of recovery.....". S/he further stated it was "...impossible to believe.....". The Medical Director further stated if it was known a	A 395	**Tag A395 (cont'd)** be reported to the Administrative Safety Quality Committee monthly, which minutes are reported to and reviewed by the Board. Patients with three or more visits over the last 60 days will be identified via a daily report and the ED nursing leadership (or other designated RN) will conduct chart audits of 100% of such encounters to assure that nursing standards of practice were met. This monitoring will occur each business day (with weekend encounters reviewed on the following Monday) for a period of at least ninety days, the results of which will be assessed as part of the Hospital's QA/PI program. The reviewer will notify the department manager of any deviations identified for immediate follow up. The results of this monitoring will be reported to the Administrative Safety Quality Committee monthly, which minutes are reported to and reviewed by the Board Safety Quality Committee. Executive Responsible: Chief Nursing Officer.	10/28/13 Ongoing Ongoing

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A 395	Continued From page 22 patient had chest pain or shortness of breath ".....absolutely the expectation would be putting patient on the monitor, EKG within 10 minutes, even more so with atypical pain, abdominal pain." Per interview on 10/8/13 at 11:00 AM, the Administrative Director of Outpatient Services stated the Nurse Manager for the ED has firm expectations if someone was not making the bar s/he would talk to the person and say you have to step it up or out. This is very unfortunate".	A 395		
A1100	482.55 EMERGENCY SERVICES The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on staff interview and record review the Condition of Participation: Emergency Services was not met as evidenced by the hospital's failure to meet the needs of patients in accordance with acceptable standards of practice for 1 applicable patient. Based on information obtained the following findings reflect an Immediate Jeopardy situation was determined to exist as the result of actual harm to a patient who sought treatment in the Emergency Department. (Patient #1) Findings include: Per Vermont Title 26: Professions and Occupations, Chapter 28: Nursing "Registered nursing" means the practice of nursing which includes: (A) Assessing the health status of individuals and groups; (H) Maintaining safe and effective nursing care rendered directly or indirectly (I) Evaluating responses to interventions; (L) Collaborating with other health	A1100	**Tag A 1100** Plan for Correction: The Hospital immediately engaged to educate all staff on the Hospital's expectations for the Culture of Safety. Starting on October 7, 2013, Nursing leadership conducted one-on-one meetings with 100% of clinical staff to provide direct education about patient safety as was summarized in the acronym C.A.R.I.N.G.: Careful Attention, Respond Immediately, Never Guess. This education was immediately shared with Hospital nursing staff. On October 14, 2013, the same information was provided to all staff (clinical and administrative) and was completed by October 18, 2013. To assess and validate staff knowledge of this education, the staff rounding log was revised to include an assessment of each staff members' competency which will be completed in one-on-one meetings with each member's manager. An educational presentation entitled Patient Safety, Communication and Privacy: An Impact on Outcomes was developed and presented to staff from the Emergency Department (nursing, technicians, unit secretaries and physicians), Access Services department and the Security department. This education focused directly on patients' right to safe care and how each employee can and must live the Hospital's Culture of Safety (C.A.R.I.N.G.). The specific modules presented, as reflected in	10/18/13 10/21/13 Ongoing 10/24/13

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A1100	Continued From page 23 professionals in the management of health care and (M) Addressing patient pain. Nursing staff on 9/24/13 to failed to maintain standards of nursing practice in the ED to include assessing the health status of Patient #1, whose medical history included multiple comorbitities. Upon arrival to the ED via ambulance at 23:07, EMS team had initially assessed the patient at his/her home where s/he complained of acute back pain, shortness of breath, abdominal pain, non radiating chest pain and nausea. Although the patient had been on a cardiac monitor and provided oxygen during transport to the hospital ED, upon transfer to an ED stretcher the cardiac monitor and oxygen was removed by EMS staff. ED nursing staff failed to provide safe and effective nursing care to Patient #1. Per interview on 10/7/13 at 1:58 PM, Nurse #1 confirmed s/he had obtained a report from EMS regarding Patient #1 to include back pain, shortness of breath and stomach pain. "She was yelling...appeared to be in quite a bit of pain". Nurse #1 further stated s/he had cared for Patient #1 in the past during previous ED visits. Nurse #1 rated the patient's pain to be a "10" (on a 1-10 pain scale/10 being the worse level of pain) but noted Patient #1 did not answer Nurse #1's questions during the Triage process stating the patient was yelling in pain. At the completion of the Triage process that was conducted on the opposite side of the large trauma bay, Nurse #1 left the area. No direction was provided by Nurse #1 to other ED staff to place Patient #1 on a cardiac monitor or apply oxygen. The only vital signs recorded, taken by the ED technician, included: B/P 130/96, pulse 88 and oxygen level via pulse ox meter was reported at 96 on room air.	A1100	**Tag A1100 (cont'd)** the Communication and Education Plan, are *Culture of Safety, Communicating for Outcomes, HIPAA and the Emergency Department, and Delivery of Care when Patient Rights were Compromised.* The sessions included experiential learning opportunities, small group work and a frank and direct discussion of the specific patient event at issue. Policies and protocols for Triage Nurse Roles and Responsibilities and Delivery of Care have been reviewed and revised. The Hospital policy entitled Delivery of Care was revised to clarify the overall process for patients to enter the ED and the specific requirements of nursing staff upon patient arrival. Revisions include the following: direction that patients are placed in specific rooms in the ED by "pod" with an RN assigned to the pod; handover communication method, content and documentation between Emergency Medical Squad member and the triage nurse; handover communication method, content and documentation between the triage nurse and the nurse assigned to care; the requirement for nursing to immediately reassess all patients upon notification of a change in the patient's condition; requirement that the initial assessment by the RN occur at the patient's bedside and include a hands-on physical assessment. The ED policy on Nursing Responsibilities was modified to clarify expectations for the management of pain. The Hospital policy entitled Triage Nurse Roles and Responsibilities was revised to require that patients arriving on oxygen and/or cardiac monitoring have these continued until the physician evaluation has been completed. The Hospital has modified its electronic medical record to provide a new standardized template for taking and	10/20/13 10/24/13 10/20/13 10/23/13

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	470012	A. BUILDING _____ B. WING _____	C 10/08/2013

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A1100	Continued From page 24 Nurse #2, who was assigned to Patient #1, sat at the nurses station located opposite the trauma bay #11 and observed Patient #1's arrival by EMS. Per interview on 10/7/13 at 12:01 PM, Nurse #2 stated s/he was on the computer and did not get up to assist staff and EMS with the patient's transfer or assess the patient's physical status once the ED technician had completed vital signs. Nurse #2 stated " ...the patient was crying out in pain...I continued my charting" and failed to address and assess the patient's obvious pain. Nurse #1 stated staff had dimmed the lights in bay #11 to "...make the patient more comfortable...I would glance over to see her/him move their arm or leg". At approximately 10 minutes after admission to the ED between 2220-2224 on 9/24/13 Access Services Registrar #1 entered bay #11 to complete the registration process, verify information and obtain a signature for treatment from Patient #1. Per telephone interview on 10/7/13 at 4:00 PM. Registrar #1 stated "I spoke to her/him a couple of times (Patient #1)...her/his head was to the side and her/his mouth was open. There was no response from her/his eyes. I was quite close to her/him. I was up by her/his head. I looked at her/his chest area to see if there was any movement." Registrar #1 reported s/he quickly went to the end of the trauma bay area and "I said to the nurses who were nearby. I said she/he (Patient #1) is dead. One of the nurses said 'oh s/he's playing possum'.....'I'll sign your papers for her/him'....S/he signed my paper and at that point I left the emergency room....I did not know if s/he was actually dead when I left the emergency department".	A1100	**Tag A1100 (cont'd)** documenting handoffs ("handovers") from Emergency Medical Services ("EMS") members to the triage nurse in the Emergency Department. This new template ensures that all essential elements of an EMS to triage nurse transfer of care will be obtained and addressed as well as documented. Completion of this template is required in 100% of patients who arrive by EMS. The Hospital policies entitled Delivery of Care and Nursing Responsibilities were revised to include a new provision requiring that patients be reassessed for any reported change in condition. Implementation: 100% of staff members in the Emergency Department, Emergency Medicine, Access Services and Security departments are required to complete a written or online competency test on the Patient Safety Communication and Privacy: An Impact on Outcomes training. As of October 25, 2013, the following staff have completed the training: • ED RNs: 97% (31/32) • ED physicians: 93% (14/15) • ED Technicians/unit secretaries, Access and Security staff: 100% The remaining two staff members are on medical leave and will not be permitted to return to duty until the competency has been completed. The understanding and competency of this education will be assessed by obtaining a passing score on a written or online test. All new staff will be provided the same material as a component of their orientation program. Emergency Department and Access Services department leadership will conduct regular, one-on-one meetings ("rounding on staff") with all employees to assess their competency with patient rights and the	10/23/13 10/24/13 10/29/13 Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A1100	Continued From page 25 Despite the comments made by Registrar #1, neither Nurse #1 or Nurse #2 went to assess Patient #1. Nurse #2 confirmed s/he saw Registrar #1 enter bay #11 and described Registrar #1 as s/he was walking out from bay #11 as ".... nervous" and "...said I think s/he's dead". Nurse #2 stated at the time of interview that " I said s/he was moving. She was sleeping. I did not go up to look at her/him....I know I should have but I didn't". Within 1-2 minutes after the Registrar's reported observations of Patient #1, Nurse #3, who was unaware of comments and concerns raised by Registrar #1, walked by bay #11 and glanced at Patient #1. Per interview on 10/7/13 at 3:15 PM, Nurse #3 stated "...s/he did not look well at all...s/he was not on a heart monitor, checked for a pulse...". Nurse described the pulse as "faint" and waved for Nurse #2, who was sitting at the nurses station, to come to bay #11. Per nursing note written by Nurse #1 at 2327, "...RN walked by Pts. room, noted Pt. to appear cyanotic, Pt. found to be pulseless and apnic (not breathing), CPR initiated". Resuscitation for cardiac arrest continued for 20 minutes. Patient's condition did not improve, the code was ended and time of death was noted to be 2351. Per ED Triage Protocol: Chest Pain, last reviewed 02/13 states "Triage protocols are an effective way to provide timely diagnostics and gain efficiencies for provision of services to select patients based on presenting signs and symptoms. The use of standardized approach to triage to facilitate medical decision making by the provider." Nursing orders for ED Triage for chest pain includes : "Vital signs; 02 per titration guidelines; saline well (IV) and cardiac monitor".	A1100	**Tag A1100 (cont'd)** culture of safety. Any lack of understanding or noncompliance identified in these meetings will be immediately and directly addressed with the staff member through the Hospital's Corrective Action policy. The Administrative Director of Inpatient Services will review these rounding tools each month to ensure 100% of staff has participated. The ED Clinical Nurse Specialist (or other designated RN) and Access Services supervisor have provided direct, one-on-one education with staff on the changes to the policy and the Consent form which has been documented and tracked via a sign-off sheet. 100% of ED and Access Services staff have completed the training except for one RN on medical leave who will not be permitted to return to duty until the training has been completed. The understanding of this education will be assessed by obtaining a passing score on a written or online test. The ED charge nurses ("Designees") will provide timely oversight of general nursing care and in particular, treatment of patient arrivals by Emergency Medical Services squads, for compliance with nursing care standards of practice. The Designee will provide direct in-person correction of any noncompliance and refer it to the ED Manager to be addressed in conjunction with the Corrective Action policy. Monitoring: The ED nursing leadership (or other designated RN) will conduct chart audits of 100% of Emergency Department patient encounters to validate compliance with the Triage, Delivery of Care and Nursing Responsibilities policies, specifically addressing issues of adequate response to pain and the requirement that the assessment by the nurse be conducted at	Ongoing 10/24/13 Ongoing 10/24/13 Ongoing 10/28/13

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A1100	Continued From page 26 Per interview on 10/8/13 at 12:32 PM, the Medical Director for the ED stated s/he was made aware of the adverse patient event 1 week ago and remarked "a nurse making incredible poor judgement which may have delayed this patient having a chance of recovery.....". S/he further stated it was "...impossible to believe.....". The Medical Director further stated if it was known a patient had chest pain or shortness of breath ".....absolutely the expectation would be putting patient on the monitor, EKG within 10 minutes, even more so with atypical pain, abdominal pain."	A1100	**Tag A1100 (cont'd)** the bedside and include a physical examination. This audit will also review the completion of the EMS handoff ("handover") protocol, which includes continuation of cardiac monitoring and oxygen on patient arrivals by Emergency Medical Services squads. This monitoring will occur each business day (with weekend encounters reviewed on the following Monday) for a period of at least ninety days, the results of which will be assessed as part of the Hospital's QA/PI program. The reviewer will notify the department manager of any deviations identified for immediate follow up. The results of this monitoring will be reported to the Administrative Safety Quality Committee monthly, which minutes are reported to and reviewed by the Board Safety Quality Committee. The ED nursing leadership or other designated RN will conduct chart audits of 100% of Emergency Department patient arrivals by EMS squads to validate for completion of the electronic documentation of the handoff ("handover"). This monitoring will occur each business day (with weekend encounters reviewed on the following Monday) for a period of at least ninety days, the results of which will be assessed as part of the Hospital's QA/PI program. The reviewer will notify the department manager of any deviations identified for immediate follow up. The results of this monitoring will be reported to the Administrative Safety Quality Committee monthly, which minutes are reported to and reviewed by the Board Safety Quality Committee. Patients with three or more visits over the last 60 days will be identified via a daily report and the ED nursing leadership (or other designated RN) will conduct chart audits of 100% of such encounters to assure that appropriate care was provided and there was no abuse or neglect	Ongoing Ongoing 10/28/13 Ongoing 10/28/13

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